



OFFICE OF THE STATE PUBLIC DEFENDER

RANDI HOOD
CHIEF PUBLIC DEFENDER

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Name (please print)	Date of Birth	
I authorize		
<input type="checkbox"/> to disclose and give copies to the Office of the State Public Defender, the following information now in your possession or control and to answer any questions that may be asked regarding this information.		
This authorization covers the approximate time period	From _____ To _____ <input type="checkbox"/> Any and All treatment	
Medical treatment record(s) requested		
<input type="checkbox"/> Entire Record <input type="checkbox"/> history and physical <input type="checkbox"/> admission/intake form <input type="checkbox"/> pharmacy records <input type="checkbox"/> treatment/progress notes	<input type="checkbox"/> laboratory reports/studies <input type="checkbox"/> radiographs/MRI's/imaging studies <input type="checkbox"/> physician's orders <input type="checkbox"/> nursing notes	<input type="checkbox"/> medication sheets <input type="checkbox"/> discharge summary/orders <input type="checkbox"/> HIV/AIDS diagnosis/treatment records <input type="checkbox"/> other
Mental health treatment record(s) requested		
<input type="checkbox"/> Entire Record <input type="checkbox"/> history & physical <input type="checkbox"/> education assessment <input type="checkbox"/> psychological testing	<input type="checkbox"/> diagnosis/assessment <input type="checkbox"/> progress/treatment notes <input type="checkbox"/> observation report <input type="checkbox"/> competency/sanity evaluations	<input type="checkbox"/> physicians orders <input type="checkbox"/> medication sheets <input type="checkbox"/> discharge summary/orders <input type="checkbox"/> other
Drug and alcohol treatment information requested		
<input type="checkbox"/> Entire Record <input type="checkbox"/> substance abuse evaluation <input type="checkbox"/> other records Specify: (e.g. SSA, DPHHS, billing/payment, vocational)	<input type="checkbox"/> discharge summary/orders <input type="checkbox"/> progress/treatment notes	<input type="checkbox"/> diagnosis or testing instrument <input type="checkbox"/> other
The purpose of this disclosure is: <i>legal purposes</i>	This consent expires: one year from the date of signing	
I understand that:		
<ul style="list-style-type: none">► The requested information may not be protected from re-disclosure by the Office of the State Public Defender; However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (42 C.F.R., part 2), the Office of the State Public Defender may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.► I may refuse to sign this authorization and that my refusal will not result in the termination of my representation or ability to obtain treatment, services, or affect my eligibility for benefits.► I may have a copy of this authorization► A photocopy/fax of this release is valid and may be used in lieu of the original.► I may revoke this authorization in writing at any time.		
I have read this authorization and by signing acknowledge that I knowingly and freely consent to the disclosure of this information.		
Signature (or signature of person authorized to sign)	Date of Signing	
The authorized person signing above is the: <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> other		
<i>I no longer wish to share the information indicated above with the Office of the State Public Defender and hereby revoke this authorization.</i>		
Signature	Date	